

DAY OF ACTIVITY EVALUATION

🞏 Regular Scheduled Series 🞏 Single Activity Course

**CME Activity Name**:

**Date of Event**:

**\*\*Responses are essential to ensure CME quality and credit for this activity\*\***

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| --- | --- | --- | --- |
| **As a result of attending this CME activity, which of the following do you plan to implement and/or change in your practice (check all that apply)** | **Definitely** | **Maybe** | **No or No Change Needed** |
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1. **List additional improvements or changes you plan to make as a result of attending this activity:**
2. **List any barriers that you must overcome to implement your planned improvements or changes:**
3. **What patient diseases, treatments, and/or questions, would you like further education about at future activities?**
4. **Was there evidence of commercial bias in this presentation?** 🞏 **No** 🞏 **Yes If Yes, please explain:**

**Thank you for your attendance and responses.**

**Participant Print Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_